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F 000	INITIAL COMMENTS An onsite revisit was conducted on 4/27/23. Tags F550, F580, F600, F655, F725, F804 were corrected as of 4/27/23. Repeat tags were cited. New tags were also cited as a result of the complaint investigation survey that was conducted at the same time as the revisit. The facility is still out of compliance.	F 000		
{F 677} SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interviews the facility failed to trim a dependent residents' fingernails for 1 of 3 residents reviewed for activity of daily living (Resident #11). The findings included: Resident #11 was admitted to the facility on 01/23/23 with diagnoses that included: acute respiratory failure with hypoxia and others. Review of the significant change Minimum Data Set (MDS) assessment dated 01/28/23 revealed that Resident #11's cognition was not assessed nor was the staff assessment of his cognition. The MDS further revealed that Resident #11 required extensive assistance with personal hygiene and had limitation of range of motion to bilateral upper and lower extremities. No rejection of care was noted on the MDS.	{F 677}		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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Review of a care plan revised on 02/01/23 read in part; Resident #11 had an activity of daily living (ADL) performance deficit related to trauma from multiple injuries sustained in a motor vehicle accident. The interventions included: Resident #11 is totally dependent on one staff member for personal hygiene and oral care. There was no care plan for rejection of care.

An observation of Resident #11 was made on 04/18/23 at 10:09 AM. Resident #11 was resting in bed and was alert and verbal. His bilateral hands were contracted, and Resident #11 was asked if he could open his right hand. He was able to open his right hand a small bit, enough to visualize his fingernails. The fingernails on his right hand were approximately three fourth inch long extending past the end of his finger and there was an indentation in the palm of his hand where the nails had been resting but the skin was intact. Resident #11 was asked if he could open his left hand, he was able to do so a small bit but stated "that it hurt". The thumb and two middle fingers were visualized, and the fingernails were approximately three fourth inch long extending past the end of his finger and there was an indentation in the palm of his hand where the nails had been resting but the skin was intact.

Nurse Aide (NA) #10 was interviewed on 04/18/23 at 1:48 PM. She stated that she generally worked as one member of the shower team in the facility. NA #10 stated that Resident #11 preferred bed bath so she had given him a complete bed bath "a couple of weeks ago" but could not recall the exact date and could not locate the shower sheet from that day. NA #10 stated that she could not recall the status of Resident #11's fingernail and she could not recall if she trimmed them or not.

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{F 677}	Continued From page 2 She stated it was her generally practice to clean fingernails so she believed she would have cleaned them but could not say for sure if she trimmed them or not. NA #7 was interviewed on 04/19/23 at 12:14 PM. NA #7 confirmed that she had given Resident #11 a complete bed bath on 04/14/23 and had cleaned his nails. She stated Resident #11's fingernails were long on 04/14/23 but could not explain why she had not trimmed them. NA #7 stated that she assisted Resident #11 on 04/19/23 before he was transferred to the hospital and again noticed his fingernails were long but there was not time to trim them before he left the facility earlier on the shift. The Director of Nursing (DON) was interviewed on 04/26/23 at 10:16 AM. The DON explained that the facility generally had two staff members in the shower room completing showers on a daily basis. Anytime the resident received a bath or shower she would expect the staff to perform nail care. If Resident #11 received a complete bed bath on 04/14/23 and the staff noted his nail to be long the staff should have trimmed them at that time.	{F 677}		
F 760 SS=J	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on record review, and interviews with staff and the Nurse Practitioner the facility failed to prevent a significant medication error when	F 760		

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Narcan (reversal agent used in case of overdose) was not administered as prescribed for a resident who had a known history of substance abuse that included crushing and snorting pills/medications. The Nurse Practitioner ordered Narcan as needed for overdose on 7/20/22 for Resident #3. Resident #3 was found unresponsive in his room on 8/14/22, Cardiopulmonary Resuscitation (CPR) was initiated but Narcan was not administered as ordered and the resident was unable to be revived. Nursing Assistant (NA) #11, NA #12, and Housekeeper #1 had observed a white, powdery substance on the tray table in Resident #3's room. The facility also failed to notify Emergency Medical Services (EMS) that responded to Resident #3's cardiac arrest on 08/14/22 that he had a history of drug abuse nor that there was a white powdery substance found next to him. This affected 1 of 4 residents reviewed with sudden cardiac arrest (Resident #3) Resident #3 expired in the facility on 08/14/22.

Immediate Jeopardy began on 08/14/22 when Resident #3 was found unresponsive in his room with a white powdery substance on his bedside table and the facility staff failed to administer an ordered dose of Narcan for a suspected drug overdose. Immediate jeopardy was removed on 04/23/23 when the facility provided an acceptable credible allegation of immediate jeopardy removal. The facility will remain out of compliance at lower scope and severity D (no actual harm with more than minimal harm that is not immediate jeopardy) to ensure monitoring systems are in place and the completion of staff education.

The findings included:

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Resident #3 was admitted to the facility on 11/10/20 with diagnoses that included cocaine dependence, congestive heart failure, and chronic respiratory failure.

Resident #3's quarterly Minimum Data Set (MDS) assessment dated 06/17/22 revealed he was cognitively intact with no psychosis, behaviors, or rejection of care. Resident #33 was coded with having frequent pain and he received opioids 7 of 7 days during the lookback period. The MDS revealed Resident #3 was born in 1960 indicating he was 62 years old.

Review of Resident #3's physician orders revealed the following physician orders: - Oxycodone (opioid pain medication) HCl Tablet 20 milligrams (mg) - Give one table by mouth every 6 hours as needed for pain. Crush oxycodone and the patient is to take the medication in front of the nurse. The order's start date was 06/16/22 - Narcan [reversal agent used in case of overdose] liquid 4mg/0.1 milliliter (ml) - 4 mg in nostril every 6 hours as needed for overdose. The order's start date was 07/20/22.

Resident #3's care plan last updated on 07/29/22 revealed the following information: - Resident #3 exhibits or has the potential to exhibit verbal/physical behaviors related to opioid dependence and anxiety; history of snorting pills/medications, misuse of oxygen. Interventions included monitoring medication administration to ensure medications are taken and swallowed prior to leaving resident.

- Resident #3 does complain of pain at times due to impaired mobility. Resident #3 has a diagnosis

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of chronic pain and opioid dependence. Resident has pain medication in place and is followed by pain clinic." Interventions included "Per MD order Narcan 1 milliliter by nasal route as needed for opioid overdose. Repeat every 2 minutes until emergency medical services arrive."

An interview with the Pharmacist on 04/21/23 at 12:12 PM revealed they received the physician order for Narcan on 07/20/22 and that the prescription was filled and delivered on 07/21/22. She reported the Narcan they sent would have had Resident #3's name on it along with the dosing schedule.

A review of Resident #3's medication administration record from August 2022 revealed the order for Narcan to be administered in the event of an overdose. No dose of Narcan was signed off on as having been given on 08/14/22.

A review of Resident #3's physician progress notes revealed a note from 08/03/22 that included the following: "Behavioral concerns - this NP [Nurse Practitioner] recommends that the patient be discharged from this facility for numerous documented reports from the staff of overdose, abuse, and noncompliance. I believe that the patient puts the facility at risk for liability if he were to overdose. I have added Narcan 4mg [Milligrams] nasal every 6 hours as needed for overdose. I have expressed by concerns with the [Former] Director of Nursing, Administration, and Medical Director." The note was electronically signed by NP #2.

During an interview via telephone on 04/20/23 at 9:01 AM with Nurse Practitioner (NP) #2 reported she was no longer working at the facility. She

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reported Resident #3 had a history of taking his narcotic pain medication and then turning his oxygen up on his portable tanks and concentrator until he would pass out. She stated she was concerned about Resident #3 abusing his narcotics because she heard from unknown staff members that he pocketed the medications and then crushed and snorted them. She reported several months before August of 2022 she refused to prescribe him narcotic pain medications and referred him to a pain clinic for monitoring. The pain clinic ordered oxycodone. She reported Resident #3's narcotic pain medication was to be crushed and Resident #3 observed until it was fully taken in applesauce or another medium. She reported she received information from a staff member whom she could no longer remember, who informed her there was a picture of Resident #3 cutting a white powdery substance on his tray table in the facility that was turned into administration. She explained this was when she prescribed Resident #3 Narcan (7/20/22) to be given in the event of an accidental overdose.

The Medication Administration Record (MAR) for August 2022 revealed oxycodone was administered to Resident #33 on 08/14/22 at 2:16 AM by Medication Aide (MA) #3.

An interview with Medication Aide #3 (MA) on 04/20/23 at 3:14 PM revealed she was assigned on the medication cart and was responsible for providing Resident #3 with his medication from 7:00 PM on 08/13/22 until 7:00 AM on 08/14/22. She stated she last gave him his narcotic pain medication at 2:16 AM on 08/14/22 and found him unresponsive around 5:30 AM. She could not recall with certainty if she crushed his oxycodone

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when she last administered the medication. She went onto say that she would have administered them as it was ordered on the MAR. MA #3 stated she had worked with Resident #3 a few times previously and she remembered reading in his chart that he had some drug seeking behaviors. She revealed when she worked with him, he came up to her medication cart before he was due to receive his narcotic pain medication and waited there until it was time for it to be administered. She further stated Resident #3 did not have a physician order for Narcan because she would have made a note to herself. She also reported she did not have Narcan on her cart and that it would have been out of the ordinary for a resident to have a physician order for Narcan. She reported during the entirety of time she assisted with Resident #3's emergency, she never saw anyone administer Narcan or tell EMS personnel when they arrived that Resident #3 had a history of drug abuse. Med Aide #3 indicated she had not received any formal education on how to administer Narcan nor any education on how to identify a resident who had an overdose.

A nurse progress note completed by Nurse #13 dated 08/14/22 at 7:28 AM read in part, "Resident #3 reported on floor at 6:15 AM by [Med Aide #3] following ambulation by resident from smoking area ...emergency medical services [EMS] notified by staff while this nurse and additional nurse performed cardiopulmonary resuscitation in resident room. EMS arrived at 6:25 AM ...Resident #3 pronounced expired by EMS at 6:46 AM."

During an interview with Nurse #13 via phone on 04/20/23 at 3:44 PM, he reported he responded to calls for help from MA #3. He stated he went to

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Resident #3's room and found him on the floor, still warm but with no pulse or respiration. He stated he immediately called a code blue and began chest compressions. Nurse #13 stated Resident #3 was not on his assignment, and he did not know anything about Resident #3's medical history including past drug abuse or overdoses. He stated he had no reason to suspect a drug overdose and stated that Narcan was not administered by him. He reported he was assigned to oversee the Medication Aide #3 on that hall but stated he had no knowledge of Resident #3's medical history or care needs.

A review of the EMS run report from 08/14/22 at 6:25 AM revealed they arrived at the facility and began CPR on an unresponsive resident. Per the report, the responding EMS personnel were not informed of a potential overdose situation when they arrived or at any time while they provided emergency assistance to Resident #3.

An interview with NA #11 (agency) on 04/20/23 at 12:05 PM via telephone, she reported she was assigned to Resident #3 on 8/14/22 on 3rd shift. She stated MA #3 went into Resident #3's room to give him his medications around 5:00 AM and found him unresponsive. She reported MA #3 screamed for assistance and she and NA #12 went running. She stated when she got to the room, she noticed a white, powdery substance on Resident #3's tray table.

Interview with NA #12 (agency NA) on 04/20/23 at 12:35 PM revealed she worked the night of 8/14/22 Resident #3 and had run to the room when MA #3 called for help after finding him unresponsive. She stated when she arrived at the room, she noticed a white, powdery substance on

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his side table.

An interview with Housekeeper #1 on 04/20/23 at 3:33 PM via telephone, revealed she went into Resident #3's room on 8/14/23 and wiped off a white, powdery substance from his tray table. She reported she did not know Resident #3's medical history or if he had a history of substance abuse. She reported she only wiped off the tray table after EMS requested her to do so. She could not provide any information on why EMS asked her to wipe off Resident #3's tray table.

During an interview with NA #7 on 04/19/23 at 3:28 PM she reported she believed Resident #3 died due to an overdose due to her experience of seeing him snort an unidentified powdery substance on more than one occasion. NA #7 stated each time she observed Resident #3 snorting a white substance, she stopped him and got the nurse on the hall. She reported by the time she and the nurse returned to the room, the white, powdery substance was gone, and Resident #3 stated it was baby powder and denied snorting it. She reported she also wrote two separate reports regarding what she observed and slid them under Administrator #3's door. NA #7 stated she could not remember the dates she completed the reports but was certain she slid them underneath Administrator #3's door. She reported to her knowledge, nothing was done to prevent Resident #3 from snorting a white, powdery substance.

Administrator #1 was asked on 04/19/23 at 4:30 PM to locate the written statements from NA #7 regarding Resident #3's observed behaviors of crushing and snorting his medications but she reported on 04/20/23 at 10:00 AM she was

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unable to locate them.

An interview with Resident #3's former roommate, Resident 13, was conducted via telephone on 04/21/23 at 1:16 PM revealed he had reported Resident #3's drug abuse to facility staff multiple times including to the Wound Nurse and to former Social Worker #1. He stated he even sent pictures and video he had taken on his cell phone to them on their personal cell phones. Resident #3's former roommate reported he felt that someone from the facility was bringing in either cocaine or opioids and providing them to Resident #3. He stated he watched Resident #3 numerous times pull out pills, chop them up on his tray table, and snort them.

On 04/21/23 at 12:18 PM the photograph and video recorded by Resident #13 was reviewed. They showed Resident #3 sitting in his wheelchair, in his room, next to his bed with his back to the door. Resident #3 was wearing a lime green t-shirt and had a bank debit card in his hand pressing the edge down onto a white, powdery substance that was on his tray table beside his bed.

An interview with the Wound Nurse on 04/21/23 at 12:01 PM via telephone revealed it was very well known that Resident #3 had a substance abuse problem and crushed his opioid medications and snorted them. She also reported she had received a photograph and a short video, unable to recall the date, from Resident #3's roommate, Resident #13, that showed Resident #3 using a credit card to "cut" a white, powdery substance on his tray table in his room at the facility. She reported she immediately sent them to Director of Nursing #3 and provided them to a

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Corporate Staff member who was a female. She was unable to remember her name or her position. She stated she also wrote a statement, unable to recall the date, and provided it to the Corporate Staff member. The Wound Nurse reported she heard nothing back from Director of Nursing #3 or the Corporate Staff member about the situation. The Wound Nurse reported she felt that the situation was ignored.

Interview with the former Social Worker #1 via telephone on 04/21/23 at 3:15 PM revealed she remembered Resident #3 and that he had a history of abusing his medications by crushing and snorting them. She reported Resident #3's former roommate, Resident #13, had approached her in her office some time, unable to recall the date, and told her Resident #3 was storing medications under his tongue then crushing and snorting them. She stated she brought it up to Director of Nursing #3 and Administrator #3 immediately after being informed, but it was "blown off". She stated, "everyone knew about it, and no one did anything". She reported there were no additional interventions put into place to increase supervision and despite his behaviors being discussed "weekly" at morning meeting; it "was always not taken seriously".

An interview was attempted with Director of Nursing #3 and was unsuccessful.

An interview was attempted with Administrator #3 by telephone and was unsuccessful.

An interview with Director of Nursing (DON) #1 on 04/26/23 at 10:26 AM, revealed although she was not working in the facility at the time of the incident, if there was a suspected overdose

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situation with a resident with a known substance abuse issue, who had a physician order for Narcan, she expected her staff to administer the Narcan as ordered. She also reported she expected the medication aides and the hall nurses to know which residents were at risk for overdose and administer Narcan as ordered. She reported she also expected her medication aides and hall nurses to be educated on how to administer Narcan and to notify responding EMS personnel on the drug abuse history of the resident in distress immediately upon their arrival.

During a follow up interview with Nurse Practitioner (NP) #2 via phone on 04/20/23 at 4:00 PM, she stated due to Resident #3's history of drug abuse, along "with continued observed abuses of his opioid medications while admitted to the facility she prescribed Narcan to be administered "not if but when" Resident #3 overdosed." She reported the Narcan was on the medication cart and should have been dedicated to Resident #3. She stated the failure of the facility to administer the ordered Narcan was a significant medication error and reported if it had been given, more than likely, could have saved Resident #3's life. She reported giving Resident #3 a dose of Narcan if he was having a genuine cardiac arrest of respiratory failure situation would have had no significant adverse effect. She reported when Narcan was ordered, it should have shown up directly under Resident #3's opioid prescription because that was the medication, she was worried he would overdose using.

Administrator #2 was notified of the immediate jeopardy on 07/21/22 at 4:33 PM.

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The facility provided the following credible allegation of immediate jeopardy removal:

Identify those residents who have suffered, or likely to suffer, a serious adverse outcome as a result of the noncompliance:

Resident #3 was identified as having a significant medication error. Resident #3 was found unconscious on 8/14/22 with a white, powdery substance noted on the bedside and NARCAN was not administered. Resident #3 had a history of substance abuse. Resident #3 expired on 8/14/22 at the facility.

All current residents that have a history of drug abuse have the potential to be affected. A list was made by the Chief Nursing Officer of the residents who had a history of polysubstance abuse. The list was placed on the nurse carts and placed in the narc book. The Director of Nursing will be responsible for updating the list with new admissions that have a history of polysubstance abuse.

Specify the action the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or recurring, and when the action will be complete:

On 04/22/23, the Director of Nursing and Chief Nursing Officer educated licensed nurses and medication aides on the administration of NARCAN in the event a resident with known drug use history should be found unconscious and that residents with history of polysubstance abuse had physician order for NARCAN. Education also included signs and symptoms of overdose and nursing communication shift to shift on residents

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F 760	Continued From page 14 with history of polysubstance abuse and presence of list of residents with history of polysubstance abuse being located in the narc book on the cart for ease of access. Furthermore, education included notifying EMS upon their arrival of the substance abuse history and the administration of Narcan. The Director of Nursing will ensure no licensed nurses or medication aides will work without receiving this education. Any new hires including agency will receive education prior to the beginning of their next shift. Education will be completed on 04/22/2023 by the Director of Nursing or Chief Nursing Officer. Effective 04/22/2023, Administrator #2 will be responsible to ensure implementation of this IJ removal plan for this alleged non-compliance. The alleged date of IJ removal is 04/23/23. On 04/26/23 and 04/27/23 the credible allegation of immediate jeopardy was validated. A full list of residents with histories of drug abuse was observed at the nurses' stations and on the medication carts. The interviewed medication aides and nurses were aware of the individuals identified by the facility as having histories of drug abuse and were also able to articulate what they needed to do in a suspected overdose situation and how to administer doses of Narcan. The facility's immediate jeopardy removal date of 04/23/23 was validated.	F 760		
F 867 SS=E	QAPI/QAA Improvement Activities CFR(s): 483.75(c)(d)(e)(g)(2)(i)(ii) §483.75(c) Program feedback, data systems and monitoring. A facility must establish and implement written	F 867		

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policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following:

§483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement.

§483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at §483.70(e) and including how such information will be used to develop and monitor performance indicators.

§483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such development, monitoring, and evaluation.

§483.75(c)(4) Facility adverse event monitoring, including the methods by which the facility will systematically identify, report, track, investigate, analyze and use data and information relating to adverse events in the facility, including how the facility will use the data to develop activities to prevent adverse events.

§483.75(d) Program systematic analysis and systemic action.

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F 867	Continued From page 16 §483.75(d)(1) The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained. §483.75(d)(2) The facility will develop and implement policies addressing: (i) How they will use a systematic approach to determine underlying causes of problems impacting larger systems; (ii) How they will develop corrective actions that will be designed to effect change at the systems level to prevent quality of care, quality of life, or safety problems; and (iii) How the facility will monitor the effectiveness of its performance improvement activities to ensure that improvements are sustained. §483.75(e) Program activities. §483.75(e)(1) The facility must set priorities for its performance improvement activities that focus on high-risk, high-volume, or problem-prone areas; consider the incidence, prevalence, and severity of problems in those areas; and affect health outcomes, resident safety, resident autonomy, resident choice, and quality of care. §483.75(e)(2) Performance improvement activities must track medical errors and adverse resident events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the facility. §483.75(e)(3) As part of their performance improvement activities, the facility must conduct	F 867		

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distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility assessment required at §483.70(e).
Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section.

§483.75(g) Quality assessment and assurance.

§483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must:

(ii) Develop and implement appropriate plans of action to correct identified quality deficiencies;
(iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements.
This REQUIREMENT is not met as evidenced by:
Based on observations, record reviews, and staff interviews, the facility's Quality Assessment and Assurance (QAA) committee failed to maintain implemented procedures and monitor interventions the committee put into place following the complaint investigations that occurred on 03/05/21, 05/07/21, 10/15/21, 09/01/22, and 02/20/23 and the recertification and complaint investigation that occurred on 05/26/22.

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This failure was for eight deficiencies that were originally cited in the areas of Resident Assessment (F637 and F641), Quality of Life (F677), Quality of Care (F689 & F695), Pharmacy Services (F760 & F761), and Administration (F835) and were subsequently recited on the current complaint investigation of 04/27/23. The repeat deficiencies during multiple surveys of record showed a pattern of the facility's inability to sustain an effective QA program.

The findings included:

This tag is cross referred to:

F637: Based on record review and staff interviews the facility failed to complete a significant change Minimum Data Set assessment within 14 days of the determination of Hospice services for 1 of 1 resident (Resident #6) for Hospice.

During the recertification and complaint investigation conducted on 5/26/22 the facility failed to complete a significant change Minimum Data Set Assessment for a resident who admitted to hospice care for 1 of 2 residents (Resident #16) reviewed for hospice.

F641: Based on record review and staff interview, the facility failed to accurately code cognition or section C of the Minimum Data Set (MDS) for 5 of 5 residents reviewed (Resident #1, Resident #7, Resident #10, Resident #11, and Resident #12). The facility also failed to accurately code the MDS in the area of indwelling catheters for 1 of 2 residents reviewed with indwelling catheters.

During the complaint investigation conducted on

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05/07/21 the facility failed to accurately code the Minimum Data Set assessments to reflect residents received dialysis therapy, this was evident for 2 of 2 residents reviewed for dialysis.

F677: Based on observation, record review, and staff interviews, the facility failed to trim a dependent resident's fingernails for 1 of 3 residents reviewed for activities of daily living (Resident #1).

During the complaint investigation conducted on 10/15/21, the facility failed to provide incontinence care prior to a resident wetting through her brief onto her draw sheet, failed to provide incontinence care to a resident who had a bowel movement, failed to provide showers as scheduled for 1 resident, and failed to provide nail care for 2 residents for 4 of 4 residents reviewed for activities of daily living for dependent residents.

During the complaint investigation completed on 09/01/22, the facility failed to provide incontinence care for 1 of 3 residents reviewed for pressure ulcers.

During the complaint investigation completed on 02/20/23, the facility failed to provide dependent residents with showers for 3 of 6 residents reviewed for activities of daily living.

F689: Based on record review, observation, and interviews with resident, Nurse Practitioner, and staff, the facility failed to implement measures to mitigate the risk of an accidental drug overdose for a resident who had a known history substance abuse that included crushing and snorting pills/medications. On 8/14/22 Resident #3 was

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found unresponsive in his room as a result of sudden onset cardiac arrest and he was unable to be revived. Nursing Assistant (NA) #11, NA #12, and Housekeeper #1 had observed a white, powdery substance on the tray table in his room. Additionally, the facility failed to provide supervision to a cognitively impaired resident (Resident #4) who was a high fall risk and was left alone and unattended in his room after a therapy session, and was later found on the floor, and was sent to the local Emergency Room (ER) then transferred to a local trauma center for treatment of his injuries that included right ninth through eleven rib fractures, right frontal bone fracture extending into the superior orbit roof and lateral orbit wall. (Resident #3 & Resident #4) This deficient practice was for 2 of 3 residents reviewed for supervision to prevent accidents.

During the complaint investigation completed on 03/05/21, the facility failed to provide a safe smoking environment for two smokers when staff failed to properly store oxygen at a safe distance from open flame and prevent a resident who utilized oxygen from smoking while his oxygen was in use for 2 of 2 residents reviewed for safe smoking. A resident lit a cigarette with his nasal cannula in his nares and his oxygen tank on while out in the designated smoking area which resulted in burns to the resident's face and high likelihood of injury to the other resident who was in the smoking area.

F695: Based on observations, record review, and staff interviews, the facility failed to keep emergency tracheostomy (surgically created airway in the front of the neck) supplies needed for an unplanned extubation (removal of airway tube) or emergency supplies for mechanical

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ventilation (ambu bag) at bedside and easily accessible for immediate use in an emergency (Resident #11). The facility also failed to change oxygen tubing as ordered and clean oxygen filters (Resident #10). This affected 2 of 3 residents reviewed for respiratory services.

During the recertification and complaint investigation survey completed on 05/26/22, the facility failed to ensure oxygen therapy was delivered at the prescribed rate ordered for 3 of 5 residents reviewed for oxygen and failed to provide routine maintenance to oxygen concentrators to ensure the air filters were free from dust and debris for 4 of 5 residents reviewed for oxygen therapy.

F760: Based on record review, and interviews with staff and the Nurse Practitioner the facility failed to prevent a significant medication error when Narcan (reversal agent used in case of overdose) was not administered as prescribed for a resident who had a known history of substance abuse that included crushing and snorting pills/medications. The Nurse Practitioner ordered Narcan as needed for overdose on 7/20/22 for Resident #3. Resident #3 was found unresponsive in his room on 8/14/22, CPR was initiated but Narcan was not administered as ordered and the resident was unable to be revived. Nursing Assistant (NA) #11, NA #12, and Housekeeper #1 had observed a white, powdery substance on the tray table in Resident #3's room. The facility also failed to notify Emergency Medical Services (EMS) that responded to Resident #3's cardiac arrest on 08/14/22 that he had a history of drug abuse nor that there was a white powdery substance found next to him. This affected 1 of 4 residents reviewed with sudden

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cardiac arrest (Resident #3) Resident #3 expired in the facility on 08/14/22.

During the complaint investigation completed on 10/15/21, the facility failed to prevent significant medication errors by not accurately transcribing and administering medication as ordered from the hospital discharge summary prescribed to treat chronic pain, shortness of breath, and anxiety for a hospice resident for 1 of 1 resident reviewed for medication errors. As a result, the resident reported her pain level was a 7 to 9 on a scale of 1 to 10 across all three shifts during her 4 days as a resident in the facility.

During the complaint investigation completed on 09/01/22, the facility failed to prevent significant medication errors when medications were not obtained and administered per the physician orders for 3 of 3 residents reviewed for medications.

During the complaint investigation completed on 2/20/23 the facility failed to prevent a significant medication error when staff failed to administer ordered doses of an IV antibiotic on 12/22/22 and 12/23/22. The Peripherally Inserted Central Catheter (PICC) (intravenous (IV) line used to administer IV antibiotics) line was replaced with a different type of IV access on 12/24/22 and the staff failed to administer the IV antibiotic on 12/24/22 and 12/25/22 for 1 of 1 resident (Resident #1) reviewed for significant medication errors. There was the high likelihood for bacterial regrowth, resistance to antibiotic, sepsis, or return to hospital due to the missed medications.

F761: Based on observation, record review, and staff interview, the facility failed to secure 1 of 4

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medications carts (Cart D) observed during medication pass.

During the complaint investigation completed on 05/26/22, the facility failed to ensure controlled substances were stored and secured using a double lock feature for 1 of 2 medication storage refrigerators. Additionally, the facility also failed to remove a local anesthetic patch placed at bedside for 1 of 1 resident.

F835: Based on record review, staff, Nurse Practitioner, and Medical Director interviews, the facility's Administration failed to provide leadership and oversight to ensure the facility had supplies that were readily available and easily accessible to immediately start Cardiopulmonary Resuscitation (CPR) when 3 of 4 residents experienced sudden cardiac arrest (Resident #1, Resident #2, and Resident #3). This practice had a high likelihood of affecting other residents.

During the complaint investigation completed on 09/01/22, the facility failed to provide effective oversight to ensure nurses obtained and administered medications as ordered for newly admitted residents. This practice resulted in missed doses of medications for 3 residents.

During an interview with Administrator #2 on 04/26/23 at 3:02 PM, she reported her quality assurance (QA) team met monthly and included the medical director, unit managers, administrative staff, and even some direct care staff. She reported she had not been involved in the QA process yet before taking over as the Administrator but planned to run the meeting and set her expectations clearly. She reported she felt there was a lack of effective leadership in the

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F 867	Continued From page 24 facility prior to her arrival and stated all the repeat deficiencies would be entered into the facility's QA program and monitored extensively to ensure compliance is met moving forward.	F 867		